BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

DERRICK J. ROBERSON	)	
Claimant	)	
V.	)	
	)	Docket No. 1,071,022
AT&T	)	
Respondent	)	
AND	)	
	)	
OLD REPUBLIC INSURANCE	)	
Insurance Carrier	)	

ORDER

Claimant requests review of the April 14, 2016, preliminary hearing Order entered by Administrative Law Judge (ALJ) Rebecca Sanders.

APPEARANCES

Zachary A. Kolich, of Shawnee Mission, Kansas, appeared for the claimant. John B. Rathmel, of Kansas City, Missouri, appeared for respondent and its insurance carrier.

RECORD AND STIPULATIONS

The Board has adopted the same stipulations and considered the same record as did the ALJ, consisting of the transcript of Preliminary Hearing from April 13, 2016, with exhibits attached and the documents of record filed with the Division.

ISSUES

The ALJ denied claimant's preliminary hearing requests, finding claimant's injuries did not arise out of and in the course of his employment with no causal connection between claimant's symptoms and work activities.

Claimant appeals, arguing he has proven his neck, upper back and shoulder injuries arose out of and in the course of his employment and that his work-related repetitive traumas were the prevailing factor in causing his injuries, medical condition and need for reasonable and necessary medical treatment. Therefore, claimant contends the ALJ's Order should be reversed and remanded with specific instruction that authorized medical

treatment be provided, along with payment of temporary total disability benefits and reimbursement of unauthorized medical expenses.

Respondent argues the Order should be affirmed.

The issues raised by claimant on appeal are:

1. Did the ALJ exceed her jurisdiction in arriving at the legal determination(s) set forth in the April 14, 2016, preliminary order?

2. Did claimant's injuries arise out of and in the course of his employment with respondent?

3. Is claimant entitled to authorized medical treatment?

4. Is claimant entitled to temporary total disability benefits?

5. Is claimant entitled to $500 as unauthorized medical reimbursement?

FINDINGS OF FACT

Claimant began working for respondent out of Kansas City, Missouri, in May 2013 as a premises technician, installing cable TV service. On March 10, 2014, claimant was sent to Topeka, Kansas, to complete installation orders. He was in Topeka through March 28, 2014, and stayed in a hotel paid for by respondent and drove a company van. He was not allowed to drive back and forth between Kansas City and Topeka.

Claimant testified he was required to climb telephone poles using a 26 foot ladder and to crawl into spaces, attics and basements to run cable wire and make sure there was a cable signal throughout the home. Claimant stated his job usually required that he lay down or hunch over or be in whatever position was necessary to get the job done. He wore a tool belt or carried a bag of tools necessary for the job. The weight of the belt depended on what tools he carried, but the belt would generally weigh from 10 to 35 pounds. He indicated the tool bag weighed anywhere from 35 to 40 pounds. Claimant also indicated the ladder weighed about 90 pounds and had to be manually moved on and off the truck and to and from the job sites.

Three days before claimant returned to Kansas City, he noticed pain in his low back area. Claimant denied pain in his mid or upper back at that time. Claimant reported his low back pain to respondent, but his claim was ultimately denied. Claimant acknowledged he had a prior back injury in 1996.

On March 28, 2014, claimant sought treatment with Dr. Steven Braton, his primary care physician. He was referred to Dr. Steven Braun for epidural injections in his low back.

A couple days after his first injection, claimant reported pain in his upper back. He returned for trigger point injections. Claimant was also sent to physical therapy for his shoulders and back.

Claimant last worked on April 14, 2014. He testified he has been unable to work because of his left shoulder and upper back pain and continuous headaches. Claimant testified he has difficulty sleeping and it takes him a couple of days to recover when he carries anything with his left arm. Also, sitting for long periods of time causes him pain. He testified that, on an average, his pain level is 7 out of 10 on the pain scale. Claimant was given light duty restrictions, but respondent has been unable to accommodate.

Claimant testified his pain has progressively worsened and now goes down his left arm and into his fingers. Claimant denies any headaches, neck pain, upper back or left shoulder problems before March 10, 2014. He also denies receiving prior medical care from a doctor for any reason relative to those areas. Claimant indicated his head, neck, upper back and left shoulder were 100 percent with no real physical problems or complaints before beginning the Topeka job on March 10, 2014.

Claimant met with orthopedic surgeon Edward J. Prostic, M.D., for an examination on October 3, 2014, at the request of his attorney. Claimant's greatest areas of concern were his neck and upper back between the shoulder blades, with some pain going to the left arm. Claimant also reported occasional numbness and tingling going to his left ring and little fingers. His pain was worsened by looking upward and with other motions of his neck and with active use of his arms. Claimant also complained of a low back ache. However, the low back examination revealed satisfactory alignment, no tenderness and no neurological deficit. Claimant's lumbar spine range of motion was only mildly restricted.

Dr. Prostic opined claimant sustained injuries to his shoulders, cervical and thoracic spine during the course of his employment from March 10, 2014, through March 28, 2014. Dr. Prostic identified mild cervical spinal stenosis and numerous abnormalities on an earlier performed MRI that did not appear sufficient to cause the severity of claimant's symptoms at the time of the examination.

Dr. Prostic recommended claimant add anti-depressant medication to his regimen to see if they lessen his symptoms. He also recommended claimant return to light duty employment. Finally, Dr. Prostic opined the repetitious minor trauma from March 10, 2014, through March 28, 2014, is the prevailing factor in the injury, the medical condition and the need for medical treatment.

In a letter to claimant's attorney dated October 31, 2014, Dr. Prostic noted his review of the records of Dr. Brennen Bittel, which included the MRI of the left shoulder indicating evidence of a partial thickness tear of the rotator cuff. Dr. Prostic wrote it was his understanding that claimant had a worsening of radicular symptoms and shoulder pain since his last examination of claimant. Dr. Prostic recommended claimant have a

subacromial steroid injection and physical therapy to the left shoulder. He also felt shoulder shrug exercises may be beneficial. His opinion regarding prevailing factor did not change.

On July 21, 2015, Dr. Prostic wrote that, after reviewing claimant's records from the VA Hospital, he felt the physical therapy to the spine was reasonable for the injury claimant sustained. He wrote his opinion related to claimant's spine did not change.

Claimant met with Erich J. Lingenfelter, M.D., for a court-ordered independent medical examination (IME) on February 27, 2015. Claimant reported that, in addition to his chronic low back pain, he began to have headaches, shoulder pain, upper back pain and neck pain while on assignment for respondent in Topeka. Claimant indicated his shoulder was the problem and focused on that. However, he described his pain as being more in the thoracic spine. Claimant noted no specific incident as the cause of his pain.

Dr. Lingenfelter indicated claimant met with Dr. Fox, who told claimant there was nothing wrong with his shoulder and the pain was not coming from that. Dr. Lingenfelter described the shoulder MRI with age related partial thickness tearing as so unimpressive it was almost not worth mentioning.

Dr. Lingenfelter examined claimant and opined he had chronic pain. He found no pathology in the shoulder that is related to what claimant described. Dr. Lingenfelter indicated claimant did not focus on his shoulder until it was suggested to him, but when asked to pinpoint a specific area he was unable to do so. He indicated there was no evidence objectively, clinically or radiographically to suggest that there is any injury related to the shoulder. Dr. Lingenfelter had no opinion about the headaches and the dizziness, but in his entire career he had never seen this mechanism or any shoulder pathology presented in a way as bizarre as this, nor with this problem causing headaches, even if there was impingement or true rotator cuff pathology. In terms of the shoulder, Dr. Lingenfelter felt claimant should be released to normal duty. Finally, Dr. Lingenfelter wrote that if, for some reason, treatment was initiated, trigger point therapy and physical therapy for deep tissue and cortisone injections would be appropriate. Dr. Lingenfelter stated he would be scared to operate on claimant. He found claimant's condition to be over the top dramatic and unimpressive objectively.

Claimant met with orthopedic surgeon Fermin J. Santos, M.D., for a court-ordered examination on October 5, 2015. Claimant's complaints were neck, thoracic back and left shoulder pain since March 25, 2014. Claimant noticed an increase in his low back pain after work on March 24, 2014. Claimant reported a history of low back pain since the 1990's. Claimant also complained of numbness and tingling in the left upper extremity, extending into the 4th and 5th digits.

Claimant rated his pain at 5 to 7 out of 10. Claimant felt the pain in his left shoulder was worse than in the other areas and he had difficulty lifting his arm over his head. He

continued to have numbness. He also complained of less severe symptoms on the right side of his neck and of residual headaches and dizziness since the injury. Claimant reported he had been released to full duty, but was unable to work because of his pain. Dr. Santos examined claimant and determined claimant to have left shoulder pain; left shoulder impingement; left neck pain, left upper extremity paresthesias; left thoracic back pain; and chronic low back pain.

Dr. Santos opined claimant's presentation appeared to be more of left shoulder pain than cervical radiculopathy. During the physical examination, Dr. Santos noted disproportionate psychomotor responses with a Waddell's score of 2/5. The left shoulder MRI indicated a low-grade partial thickness articular surface tear. He opined claimant's complaints appear more in the left shoulder than cervical and claimant's symptoms appear more muscular in nature given the diffuse nature of claimant's pains. An updated MRI was recommended.

Claimant continued to have left shoulder pain with above the head activity when he met with Dr. Santos on December 17, 2015. Claimant's pain was worse in his upper trapezius and lateral shoulder and he had intermittent numbness in his left arm. Claimant reported concern with the weakness in his left shoulder. The updated MRI indicated no changes in claimant's left shoulder, indicating mild rotator pathology. The Waddell's test again indicated a positive response with disproportionate psychomotor responses.

Claimant was diagnosed with tendinosis of the left shoulder with no high-grade rotator cuff tear, left shoulder impingement syndrome, myofascial neck pain, left upper extremity paresthesias, but with a normal EMG and no nerve root compression on MRI, myofascial thoracic back pain and chronic low back pain.

Dr. Santos noted conservative pain management had failed and referred claimant to a shoulder specialist. He opined that if the shoulder specialist did not recommend treatment, claimant should be sent for a Functional Capacity Evaluation (FCE). Claimant was allowed to return to light duty with a 10 pound lifting restriction.

Claimant met with orthopedic surgeon Lowry Jones, M.D., on January 4, 2016, with left shoulder pain, left arm weakness, headaches, pain throughout the upper back and some numbness and tingling in his left ring and small fingers. Claimant denied any specific injury, but reported his pain started in March 2014. Claimant had epidural and trigger point injections, which did not help. EMG and MRI studies were read as normal, except for a partial rotator cuff tear in the left shoulder.

Dr. Jones examined claimant, noting the partial rotator cuff tear of the left shoulder and tendinitis of the left biceps. Dr. Jones felt the shoulder problems were secondary to claimant's upper back and neck pain. Dr. Jones opined claimant's examination expressed more weakness than pain and posed more concern about neurological problems. He felt claimant's shoulder pain was secondary and any treatment to the shoulder would not

resolve his symptoms. He wrote he had "no other explanation for his pain from a standpoint cervical, upper back or muscular explanations . . .". He recommended an FCE and permanent restrictions of no repetitive reaching, pushing or pulling overhead with a maximum lift of 20 pounds. He did not consider claimant a good candidate for surgery on the left shoulder.

Regarding causation, Dr. Jones opined that within a reasonable degree of medical certainty, claimant did have an onset of pain in 2014, but there was no specific injury. With no significant diagnostic or pathologic finding, Dr. Jones did not have a good explanation for claimant's ongoing symptoms. He was not sure he understood the prevailing cause for claimant's complaints.

PRINCIPLES OF LAW AND ANALYSIS

K.S.A. 2013 Supp. 44-501b(b)(c) states:

> (b) If in any employment to which the workers compensation act applies, an employee suffers personal injury by accident, repetitive trauma or occupational disease arising out of and in the course of employment, the employer shall be liable to pay compensation to the employee in accordance with and subject to the provisions of the workers compensation act.
> (c) The burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends. In determining whether the claimant has satisfied this burden of proof, the trier of fact shall consider the whole record.

K.S.A. 2013 Supp. 44-508(e) states:

> (e) "Repetitive trauma'' refers to cases where an injury occurs as a result of repetitive use, cumulative traumas or microtraumas. The repetitive nature of the injury must be demonstrated by diagnostic or clinical tests. The repetitive trauma must be the prevailing factor in causing the injury.
> "Repetitive trauma'' shall in no case be construed to include occupational disease, as defined in K.S.A. 44-5a01, and amendments thereto.
> In the case of injury by repetitive trauma, the date of injury shall be the earliest of:
> (1) The date the employee, while employed for the employer against whom benefits are sought, is taken off work by a physician due to the diagnosed repetitive trauma;
> (2) the date the employee, while employed for the employer against whom benefits are sought, is placed on modified or restricted duty by a physician due to the diagnosed repetitive trauma;
> (3) the date the employee, while employed for the employer against whom benefits are sought, is advised by a physician that the condition is work-related; or
> (4) the last day worked, if the employee no longer works for the employer against whom benefits are sought.
> In no case shall the date of accident be later than the last date worked.

K.S.A. 2013 Supp. 44-508(f)(1)(2)(A) states:

> (f)(1) "Personal injury'' and "injury'' mean any lesion or change in the physical structure of the body, causing damage or harm thereto. Personal injury or injury may occur only by accident, repetitive trauma or occupational disease as those terms are defined.
> (2) An injury is compensable only if it arises out of and in the course of employment. An injury is not compensable because work was a triggering or precipitating factor. An injury is not compensable solely because it aggravates, accelerates or exacerbates a preexisting condition or renders a preexisting condition symptomatic.
> (A) An injury by repetitive trauma shall be deemed to arise out of employment only if:
> (i) The employment exposed the worker to an increased risk or hazard which the worker would not have been exposed in normal non-employment life;
> (ii) the increased risk or hazard to which the employment exposed the worker is the prevailing factor in causing the repetitive trauma; and
> (iii) the repetitive trauma is the prevailing factor in causing both the medical condition and resulting disability or impairment.

K.S.A. 2013 Supp. 44-508(g) states:

> (g) "Prevailing'' as it relates to the term "factor'' means the primary factor, in relation to any other factor. In determining what constitutes the "prevailing factor'' in a given case, the administrative law judge shall consider all relevant evidence submitted by the parties.

Claimant has undergone multiple examinations and evaluations for the complaints stemming from his work duties from March 10, 2014, through March 28, 2014. Claimant initially complained of low back pain. After receiving treatment, including injections, for his low back pain, claimant then realized the pain also extended into his mid and upper back and left shoulder and upper extremity. Multiple tests have failed to uncover ongoing pathology in those areas, except for tendinosis and a partial rotator cuff tear in the left shoulder. Medical reports have described these findings as age-related and have noted claimant's giveway weakness, positive Waddell's signs and disproportionate psychomotor responses.

Dr. Prostic, claimant's expert, is the only examining physician to find an ongoing need for medical treatment stemming from this series of traumas. Even he noted claimant's mild cervical spinal stenosis and numerous abnormalities did not appear sufficient to cause the severity of claimant's ongoing symptoms.

This Board Member finds claimant did suffer a series of trauma stemming from his duties with respondent. However, the initial complaints in claimant's low back appear to have subsided and then progressed into claimant's mid and upper back and left upper extremity, including the shoulder.

Claimant's current need for medical treatment does not appear to stem from the initial low back complaints, but, are instead, related to the upper back and primarily left shoulder problems. Except for Dr. Prostic, none of the health care providers have found claimant's job duties to be the prevailing factor in claimant's ongoing need for medical care. Dr. Santos could only speculate that the symptoms "could" be related to the work activities while Dr. Lingenfelter found no relationship between claimant's symptoms and the work activities.

This Board Member finds that, while claimant has proven an initial series of trauma, the current complaints have not been sufficiently explained and the prevailing factor for claimant's alleged ongoing need for medical treatment has not been connected to claimant's job duties with respondent. The Order of the ALJ denying claimant's preliminary hearing requests is affirmed.

By statute, the above preliminary hearing findings and conclusions are neither final nor binding as they may be modified upon a full hearing of the claim.[1] Moreover, this review of a preliminary hearing Order has been determined by only one Board Member, as permitted by K.S.A. 2014 Supp. 44-551(l)(2)(A), unlike appeals of final orders, which are considered by all five members of the Board.

CONCLUSIONS

After reviewing the record compiled to date, the undersigned Board Member concludes the preliminary hearing Order should be affirmed for the above stated reasons.

DECISION

WHEREFORE, it is the finding, decision and order of the undersigned Board Member that the Order of Administrative Law Judge Rebecca Sanders dated April 13, 2016, is affirmed.

[1] K.S.A. 2014 Supp. 44-534a.

IT IS SO ORDERED.

Dated this _____ day of June, 2016.

_____
HONORABLE GARY M. KORTE
BOARD MEMBER

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